SEMI-ANNUAL REPORT
TO THE LEGISLATURE

MANDATORY ENROLLMENT OF SENIORS AND PERSONS WITH DISABILITIES INTO MEDI-CAL MANAGED CARE

July through December 2012

Department of Health Care Services
Medi-Cal Managed Care Division

Table of Contents

MANDATORY ENROLLMENT OF SENIORS AND PERSONS WITH DISABILITIES INTO MEDI-CAL MANAGED CARE

I. INTRODUCTION

Senate Bill (SB) 208 (Steinberg, Chapter 714, Statutes of 2010) permits the Department of Health Care Services (DHCS) to mandatorily enroll Medi-Cal eligible seniors and persons with disabilities (SPDs) into Medi-Cal managed care health plans (MCPs). This mandatory enrollment of SPDs does not apply to SPDs with Medicare coverage, SPDs with other health coverage, or SPDs in fee-for-service (FFS) Medi-Cal with a share-of-cost.

By delivering health care services to this high-risk population through MCPs, DHCS will be able to provide SPD beneficiaries with a high-quality system of care that improves access and care coordination.

Welfare and Institutions (W&I) Code Section 14182(s)(1) requires DHCS to provide semi-annual reports to the Legislature that provide details of the activities undertaken for the identification, notification, education, and enrollment of SPDs into MCPs. These reports include key milestones for mandatory SPD enrollment into MCPs, DHCS's progress toward the objectives of SPD enrollment, and issues related to the care management and care coordination of SPDs. This report is the *fifth* semi-annual report to the Legislature covering the period of July 1, 2012 through December 31, 2012.

Note: All updates since the last semi-annual report are in italics for ease of reference.

II. BACKGROUND

DHCS contracts with MCPs to arrange for the provision of health care services for approximately 4.9 million Medi-Cal beneficiaries in 30 counties. DHCS provides health care through three models of managed care:

1. Two-Plan Model (TPM), which operates in 14 counties;
2. County Organized Health System (COHS), which operates in 14 counties; and
3. Geographic Managed Care (GMC), which operates in two counties.

DHCS also contracts with two specialty health plans: AIDS Healthcare Foundation, and Family Mosaic.

III. KEY MILESTONES FOR MANDATORY SPD ENROLLMENT

Key Milestone	Completion Dates
Plan Readiness	January 2011
Sensitivity Training	January 2011
Access/Facility Site Review	January 2011
Outreach and Education	February 2011
Risk Assessment and Stratification	April 2011
Federal Approval of Waiver, Rates, and Contract Language	May 2011
SPD Mandatory Enrollment	June 2011 – May 2012

A. Enrollment—June 2011- May 2012

By May 1, 2012, the SPD enrollment process was complete with the transition of 239,731 SPDs into MCPs. At the onset of the transition, when the data sharing process began, there were minor issues that DHCS worked through with the MCPs. These issues did not jeopardize member access to care. There was an increase in informational calls at the MCP level and to the Medi-Cal Managed Care Division's (MMCD) Office of the Ombudsman (OMB). Many of the informational calls made to the OMB router were duplicates, hang ups, or were self-served. The self-service feature allows members to select options that direct their call to other areas based on the caller's needs. OMB also hired five contracted employees, allowing the OMB to address more calls. DHCS continues to monitor MCPs. The review of MCP progress and member satisfaction is ongoing.

At an administrative level, there has been an increase in medical exemption requests (MERs) and fair hearing requests. Most of the SPD-related MER and fair hearing requests have been inconsistent with the continuity of care provisions in the federal Section 1115 Bridge to Reform Waiver (Waiver). Prior to enrollment, beneficiaries and providers received information regarding the continuity of care provisions pursuant to the Waiver.

MMCD continues to closely monitor OMB calls, MERs, and fair hearing requests. Any health care issues that arise are resolved as expeditiously as possible at the MCP level and in collaboration with MMCD staff, when necessary. To date the implementation of mandatory enrollment of the Medi-Cal only SPD population into the MCPs has not presented any unresolvable medical care situations.

Monthly updates regarding MERs are located on the MMCD website, in a report titled "SPD Monitoring Dashboard" at:
http://www.dhcs.ca.gov/individuals/Pages/MMCDSPDChrtsRptsData.aspx

No updates for the July through December 2012 reporting period.

IV. PROGRESS TOWARD OBJECTIVES OF SPD ENROLLMENT

A. Outreach and Education

1. Prior to the mandatory enrollment of SPDs, DHCS developed an extensive outreach and education strategy that included three separate mailings and two telephone calls that are detailed below:

    - The first mailing was a 90-day notice intended to inform SPD beneficiaries of the upcoming change to their health care delivery system. SPD beneficiaries that enrolled on June 1, 2011, received their first 90-day notice on or before March 1, 2011.
    - A telephone call followed the written notice to verbally educate beneficiaries on the upcoming change and assist with questions.
    - The second notice was a 60-day enrollment packet that included a county-specific insert notifying SPD beneficiaries of their MCP choices and additional educational information.
    - The next outreach effort was a second telephone call that focused on informing SPD beneficiaries of their ability to choose a MCP, provide assistance in the enrollment process, and address questions.
    - The 30-day "intent-to-default notice" was the final mailing. This notice was sent only to SPD beneficiaries who did not make a MCP selection. This notice informed the SPD beneficiaries that if they did not choose a MCP, DHCS would assign them to a MCP.
        - 349,732 "intent to default" letters were mailed to beneficiaries who failed to make an affirmative MCP choice during their enrollment period informing them of DHCS's intent to assign the beneficiary into a MCP. DHCS first attempts to link the enrollment of each SPD beneficiary with a MCP that also contracts with the FFS provider currently being utilized the most by the beneficiary. If a SPD beneficiary cannot be linked to a MCP through a FFS provider linkage, DHCS then utilizes its current managed care default algorithm process to assign the beneficiary to a MCP. The current default algorithm annually designates a certain percentage of the default population to each MCP in TPM and GMC counties. The percentages used are determined through consideration of certain quality and safety-net measures.

    Enrollment of transitional SPDs began on June 1, 2011 and was completed on May 30, 2012. Although the enrollment and notification process listed above has been completed, DHCS continues to educate providers and beneficiaries on working with the MCPs.

    No updates for the July through December 2012 reporting period.

2. In July 2011, DHCS began the implementation of a monthly call campaign titled "DHCS Outbound Call Survey," to Medi-Cal only SPD beneficiaries. Calls were made to SPD beneficiaries at least 45 days following their enrollment effective date. The methodology for the call survey consisted of one call attempt to each randomly selected beneficiary at least 45 days after his or her enrollment effective date.

   The DHCS Outbound Call Survey for SPDs concluded in April 2012. The following results of the DHCS Outbound Call Survey were for all managed care counties:
   - Of those who responded to the call survey, an average of 66.12 percent made an appointment.
   - Finally, of those who were asked the question "on a scale of 1-5, with 5 being the best and 1 being the worst, how would you rate your MCP?" 84 percent rated their MCP at a 3 or better (see results below).

Scale of 1-5 1=Worst 5=Best		Apr-12		Mar-12		Feb-12	
		Count	%	Count	%	Count	%
Worst	1	28	6.56%	47	11.66%	37	12.59%
	2	27	6.32%	21	5.21%	19	6.46%
	3	57	13.35%	37	9.18%	42	14.29%
	4	82	19.20%	66	16.38%	61	20.75%
Best	5	233	54.57%	232	57.57%	135	45.92%
		427	100.00%	403	100.00%	294	100.00%
	3 or higher		87.12%		83.13%		80.95%
	Average	**3 or Better Feb-Apr 2012**			**84%**		
Worst	**1**				**10%**		
	2				**6%**		
	3				**12%**		
	4				**19%**		
Best	**5**				**53%**		
					100%		

B. Risk Assessment and Stratification

W&I Code Section 14182(c)(12)(A) requires MCPs to conduct risk stratifications and risk assessments of new SPD members. The risk stratification determines a member's health status as high-risk or low-risk followed by a 45 or 105-day requirement to conduct the risk assessment of the new SPD member. The risk assessment allows the MCP to determine the health care management needs of its beneficiaries.

DHCS approves all MCP risk stratification and risk assessment tools developed by the MCPs. These tools must comply with current contract requirements and Policy Letter (PL) 12-004. *DHCS reviewed and approved all risk stratification and risk assessment tools for TPM and GMC MCPs prior to utilization and began the process of reviewing risk stratification and risk assessment tools for COHS MCPs in October 2012.*

PL 12-004 can be located at the following link: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2012/PL12-004.pdf.

In July 2011, DHCS began providing MCPs with FFS utilization and Treatment Authorization Request data for new mandatory SPD members. During the months of July through December 2012, DHCS provided MCPs with 2.6 million FFS claim records. The data sets developed for this process were fully compliant with state and federal privacy requirements.

DHCS monitors and requires MCPs to submit information on risk assessment results. The statistics can be found in the SPD Monitoring Dashboard located at the following link: http://www.dhcs.ca.gov/individuals/Pages/MMCDSPDChrtsRptsData.aspx

Risk assessments can take up to 105 days to complete. Because of this, statistics on completed assessments are only available for the first half of 2012. During the first and second quarters in 2012, MCPs stratified 49,690 SPDs as high-risk and successfully contacted 102,976 beneficiaries in total.

C. Community Based Adult Services (CBAS)

Assembly Bill 97 (Committee on Budget, Chapter 3, Statutes of 2011) eliminated Adult Day Health Care (ADHC) services as an optional Medi-Cal benefit. DHCS became the defendant in a lawsuit (Darling v. Douglas) to halt the elimination of ADHC. DHCS entered into a settlement agreement with the plaintiffs to establish a new program called CBAS that offers some of the same services as ADHC and allows beneficiaries to remain in their communities; however, CBAS has stricter eligibility requirements to achieve cost savings.

ADHC ended on February 29, 2012, and fee-for-service CBAS began on March 1, 2012. The MCPs operating in COHS counties began covering CBAS on July 1, 2012, with the exception of Gold Coast Health Plan (GCHP) in Ventura County. The TPM, GMC and GCHP MCPs began covering CBAS on October 1, 2012.

MCPs contracted with former ADHC centers that are certified CBAS providers. MCPs assume two responsibilities in relation to CBAS: 1) the assessment process to determine eligibility for CBAS, and 2) the reassessment process to ensure that CBAS members continue to receive the level of CBAS services needed. DHCS executed contract amendments outlining MCP responsibilities in managing CBAS that included rates to cover the daily provision of CBAS.

V. SUBMITTAL OF FEDERAL SPAs and WAIVERS

No updates for the July through December 2012 reporting period.

VI. HEALTH OUTCOMES OF ENROLLEES

In accordance with federal quality assurance requirements, DHCS requires contracted MCPs to report performance measurement scores annually. The scores include a number of Healthcare Effectiveness Data Information Set measures related to quality of care, access to care, and timeliness of care provided to MCP members.

In August 2011, DHCS announced the required performance measures for 2012 and subsequently published the Quality and Performance Improvement Program requirements for 2012 in MMCD All Plan Letter (APL) 11-021. This APL reflected DHCS's work to include measures relevant to SPDs and the intent to begin stratified reporting for SPDs. The objective is for MCPs to eventually report scores for some measures specifically for SPDs as well as their entire population.

Stratified reporting for SPDs will not begin until 2013 as the new mandatory SPD members will not be enrolled in MCPs long enough in 2011 (the "measurement year" for 2012 performance measure rates) to be reflected in MCP scores. The new SPD members will need to participate in their MCPs long enough for MCPs to collect enough data to generate statistically significant performance scores. *The first year that SPDs will be included in DHCS's quality measures is 2013. It will take several years before the performance measurement scores fully reflect member health outcomes in managed care.*

In December 2011, DHCS presented a draft of proposed performance measures for 2013 and began discussions with MCPs and other stakeholders to determine the best SPD stratification methodology. *DHCS finalized the measures and SPD stratification methodology in September of 2012. DHCS is currently in the process of drafting a PL to publish the approved measures.*

DHCS continues development work related to the Centers for Medicare and Medicaid Services' (CMS) required utilization data reporting for mandatory SPDs in the following areas: avoidable hospitalizations; hospital readmissions; emergency room utilization, and outcome measures related to person-centered care planning and delivery.

VII. CARE MANAGEMENT AND COORDINATION

Primary Care Providers (PCPs) must manage the care of patients with chronic health conditions, serious and complex medical needs, multiple co-morbidities, and care of the elderly and disabled. Current contract language requires MCPs to support PCPs in their case management and care coordination activities. MCPs are responsible for the coordination activities for members who receive health care services within the MCP's provider network and when members receive services from out-of-network providers.

DHCS completed modifications of the MCP contract language to further define and strengthen MCP requirements for case management and care coordination across the continuum of care for SPD members. *New contract language specifies that MCPs must complete risk stratification and risk assessments followed by the completion of individual care plans for high-risk members upon enrollment and then regularly updated thereafter.*

DHCS began monitoring MCP case management and care coordination processes by means of health plan surveys. DHCS received results for 2011 (baseline) and 2012. DHCS began the analysis of this data in December 2012.

VIII. OTHER SPD INFORMATION

A. Stakeholder Advisory Committee (SAC)

The purpose of SAC is to advise DHCS on the development and implementation of the Waiver. The Director of DHCS is the chairperson of SAC and the committee included several technical workgroups comprised of individuals chosen for their expertise in the following areas:

- SPDs
- California Children's Services Program
- Behavioral health
- Health Care Coverage Initiatives
- Dual-eligibles

The technical workgroups identify issues, develop options, and inform DHCS of issues affecting the Waiver. The last SAC meeting was held *on November 19, 2012*, and included an update on the transition of SPDs into

Medi-Cal managed care, and *information about continuity of care and monitoring. Specifically, DHCS informed SAC of its intent to issue an APL related to continuity of care in the near future, and about the development and implementation of a Medi-Cal managed care dashboard.*

B. Medi-Cal Managed Care Office of the Ombudsman (OMB)

OMB uses a Microsoft Customer Relationship Management (CRM) system that tracks incoming beneficiary phone calls. In June 2010, OMB added "SPD Access" as a tracking sub-category. OMB reviews the CRM's Case Detail by Issue Type report and the Sub-Issues and Referrals by Primary Issue report to identify trends. OMB tracks SPD access on an ongoing basis.

For the period of July 1, 2012 through December 31, 2012, OMB received 2,243 calls pertaining to the mandatory enrollment of SPDs. This accounted for 11.8 percent of all calls made to OMB (19,013) during that period. Furthermore, the number of calls regarding access issues for SPDs (39) is less than the number of calls reported in the last semi-annual SPD report regarding access issues for SPDs (126).

D. Monitoring Activities

During the first quarter in 2011, DHCS solicited stakeholder input from CMS before finalizing the report elements that are used to track and report the transition of SPDs into MCPs. The monitoring elements include, enrollment patterns; outreach results; continuity of care requests; risk assessment and stratification results; member concerns and grievances; utilization data; and care coordination data. In February 2011, DHCS presented a fully developed outline for monitoring reporting via a conference call with SAC.

DHCS has since published the resulting monitoring report, or Dashboard, which is updated on a monthly basis. The September 2012 report contains the monitoring activities through June of 2012 and is available on the MMCD website at the following link:
http://www.dhcs.ca.gov/individuals/Pages/MMCDSPDChrtsRptsData.aspx

DHCS embarked on two different projects related to the monitoring of SPDs during the second half of 2012. Through funding provided by the California HealthCare Foundation, DHCS worked with University of California Berkeley to develop and facilitate a survey for transitioned SPDs. This survey focused on a myriad of areas including continuity of care, access to care, beneficiary knowledge of managed care, and patient demographics. The results from this survey will be available in late 2013. Through funding provided by Blue Shield of California Foundation, DHCS is working with a consultant to conduct a review of current monitoring information relative to SPDs, as well as to make recommendations regarding how DHCS might structure an evaluation of the SPD

transition. These recommendations will be provided in a report during the first half of 2013.

E. DHCS/Department of Managed Health Care (DMHC) SPD Related Interagency Agreement (IA) per SB 853 (Chapter 717, Statues of 2010).

DHCS and DMHC initiated a required IA on June 1, 2011. The purpose of the IA is to facilitate provider network reviews, medical audits, and financial audits relative to the SPD population, on behalf of DHCS. Quarterly network adequacy reports are due 120 days after the close of each calendar quarter. Medical survey reports do not have a specific timeframe for completion, but they must be completed for each MCP at least once every three years. The reports are provided by DMHC and submitted to DHCS.

DHCS expanded its monitoring activities to include surveys. Relative to the SPD transition, two surveys were completed that included a general survey on beneficiary experiences after joining a MCP (DHCS Outbound Call Survey) and the medical exemption process (SPD MER Survey). The results of both surveys are included in the SPD Dashboard, which is updated on a monthly basis, and is available on the MMCD website at the following link (Note: the DHCS Outbound Call Survey results currently in the Dashboard contain the results of the initial six MCP samples. The survey results for all MCPs are located on pages 4-5 of this semi-annual report):
http://www.dhcs.ca.gov/individuals/Pages/MMCDSPDChrtsRptsData.aspx

Attachment A

Abbreviations and Acronyms

ADHC	Adult Day Health Care
APL	All Plan Letter
CBAS	Community Based Adult Services
CMS	Centers for Medicare and Medicaid Services
COHS	County Organized Health System
CRM	Microsoft Customer Relationship Management System
DHCS	Department of Health Care Services
DMHC	Department of Managed Health Care
FFS	Fee-For-Service
GCHP	Gold Coast Health Plan
GMC	Geographic Managed Care
IA	Interagency Agreement
MCP	Medi-Cal Managed Care Plan
MER	Medical Exemption Request
MMCD	Medi-Cal Managed Care Division
OMB	Office of the Ombudsman
PCP	Primary Care Provider
PL	Policy Letter
SB	Senate Bill
SAC	Stakeholder Advisory Committee
SPDs	Seniors and Persons with Disabilities
TPM	Two-Plan Model
Waiver	Federal Section 1115 Medicaid Demonstration Waiver: A Bridge to Reform
W&I	Welfare and Institutions Code